Deborah Senn
Washington Insurance Commissioner

Fact sheet: HEALTH INSURANCE REFORMS IN 1994-99

In 1994, State Insurance Commissioner Deborah Senn implemented a series of rule changes that provided broad reform in three critical areas of health insurance. In addition, the state's Basic Health Plan was expanded to provide a low-cost alternative for low-income families and individuals who could not afford other health insurance. In 1995, the reforms were codified by the Legislature and are now part of state law.

Taken together, all of these changes have guaranteed Washington residents unprecedented access to health coverage during this decade.

Here's how they work:

PRE-EXISTING CONDITIONS

This change means applicants for health insurance cannot be rejected on the basis of their health. Pre-existing condition waiting periods can be no longer than 90 days, and only can be invoked for new applicants and when the condition was treated in the previous 90 days.

This means that insurance companies cannot add special exclusions to health policies based on an individual’s pre-existing conditions. For example, they cannot single out people with bad knees, people who have survived cancer or people with congenital health problems. This kind of health condition may be cited by companies to delay coverage, but for no more than three months. Your application for coverage can never be rejected on the basis of your health, nor can companies charge you special high-risk rates based on a pre-existing condition.

PORTABILITY

Washington residents who are transferring their health coverage from one insurance company to another cannot be forced to face new obstacles or waiting periods. This rule applies even when residents are transferring coverage from self-insured employers.

In some cases, the portability rule may be confused with an employer's right to

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Fact sheet: QUESTIONS & ANSWERS ABOUT DIRECT ACCESS

Under a new Washington law, health-insurance carriers must cover direct access to women's health-care service providers when that care is appropriate. Here are some questions that may occur as the new law goes into effect, along with answers from State Insurance Commissioner Deborah Senn:

QUESTION: What exactly does the law do?

Commissioner Senn replies: SSB 5854 requires health insurers to give women direct access to specific providers of women's health care services without being forced to visit a so-called "gatekeeper" or primary-care provider first.

QUESTION: When does this law take effect?

Commissioner Senn: The law goes into effect over the course of the next year. It takes effect immediately for all new health plans. However, existing plans are affected on their annual renewal dates.

QUESTION: How can I find out when my coverage is going to be renewed?

Commissioner Senn: Your carrier should be able to tell you that with a single phone call. Part of the guidance I have given health-insurance carriers is that they must establish simple and quick procedures so that people can check this sort of information out. Women who are using direct access also deserve to know whether the carrier is going to object and perhaps challenge their use of direct access. They need to find that out in advance, too.

QUESTION: What kinds of health care are we talking about?

Commissioner Senn: The law says health carriers must include generally recognized medical specialty providers involved in women's health-care services, including nurse practitioners specializing in women's health and midwifery. The full list of services includes maternity, reproductive health services, gynecological care, general examination and preventive care, including follow-up visits as medically appropriate.

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QUESTION: Who decides if the health-care provider I want to visit is appropriate or medically necessary under the law?

Commissioner Senn: That decision will be made by health-insurance carriers,

set conditions of employment, such as not providing health coverage for the first few months on the job. In these cases, employees should take the responsibility to arrange interim health coverage on their own. (When they do so, of course, they will be protected by the portability rule.)

GUARANTEED RENEWABILITY

Under health-care reform, Washington residents are assured that their health coverage cannot be canceled at the whim of an insurance company. Now all health insurance contracts must be renewed, except in cases of nonpayment of premiums or when the subscriber has violated terms of the contract -- for example, by committing fraud.

THE BASIC HEALTH PLAN

The Basic Health Plan was created in the 1980s as low-cost health insurance for high unemployment areas of the state. Under health-care reform, the BHP was expanded statewide, with special funding to let the state help pay the cost of premiums for families and individuals whose income falls below predetermined guidelines.

Benefits available under the BHP with co-payments include preventive health care, outpatient care, hospital services, and emergency care. In late 1993, the plan was expanded to include prescription drugs and maternity care, and in 1995, mental health, chemical dependency and organ transplant services were added. (The BHP does not cover vision or dental care.)

Because of funding, the subsidized enrollment is capped at the level of funding established each biennium by the Legislature. However, the BHP remains available to other Washington families and employers satisfied with its benefits and able to pay the full cost of the plan.

For more information about the Basic Health Plan, including specific benefits and costs, please contact the BHP via its toll-free hot line: **1-800-826-2444**

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JUNE 1999